GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 27, 2022

Pamela Workman
Flushing AL Operations LLC
Suite 210
777 E Main St
Westfield, IN 46074

RE: License #: AH250408318
Investigation #: 2022A1027094
Majestic Care of Flushing AL

Dear Ms. Workman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH250408318
Investigation #:	2022A1027094
Complaint Receipt Date:	09/12/2022
Investigation Initiation Date:	09/13/2022
Report Due Date:	11/12/2022
Licensee Name:	Flushing AL Operations LLC
Licensee Address:	Suite 210 777 E Main St Westfield, IN 46074
Licensee Telephone #:	(317) 288-4029
Authorized Representative/Administrator:	Pamela Workman
Name of Facility:	Majestic Care of Flushing AL
Facility Address:	640 Sunnyside Dr Flushing, MI 48433
Facility Telephone #:	(810) 487-0045
Original Issuance Date:	09/01/2021
License Status:	REGULAR
Effective Date:	03/01/2022
Expiration Date:	02/28/2023
Capacity:	40
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	No
Resident A did not receive his medications as prescribed.	Yes
Resident A was improperly charged after going to rehabilitation.	No
The facility was understaffed.	No
Additional Findings	No

III. METHODOLOGY

09/12/2022	Special Investigation Intake 2022A1027094
09/13/2022	Special Investigation Initiated - Letter Referral emailed to APS providing details of allegations
09/13/2022	APS Referral
10/18/2022	Inspection Completed On-site
10/26/2022	Contact - Telephone call made Telephone interview conducted with Ms. Workman to obtain additional information regarding staff schedule and MARs
10/27/2022	Inspection Completed – BCAL Sub. Compliance
11/28/2022	Exit Conference Conducted with authorized representative Pamela Workman by telephone

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 9/12/2022, the department received a complaint through the online complaint system which alleged Resident A's briefs were left soiled resulting in urinary tract infections (UTIs).

On 10/18/2022, I conducted an on-site inspection at the facility. I interviewed authorized representative and administrator Pamela Workman who stated Resident A had moved into the facility in April 2022. Ms. Workman stated Resident A was appointed a new guardian shortly after moving into the facility. Ms. Workman stated Resident A had four hospitalizations or emergency room visits for the cellulitis in his legs and behaviors.

While on-site, I reviewed Resident A's hospital discharge summary reports dated 8/26/2022, 9/6/2022 and 9/8/2022 which read consistent with statements of Ms. Workman. Discharge notes dated 8/26/2022 and 9/8/2022 for Resident A's emergency room visits read final diagnosis were: 1. Adjustment reaction with aggression; acute encephalopathy; aggressive behavior. Discharge note dated 9/6/2022 read in part Resident A's discharge diagnoses were: 1. Pancytopenia 2. Metabolic encephalopathy 3. Dementia with behavioral disturbance.

While on-site, I interviewed Resident A who stated, "being here is better than being somewhere else." Resident A stated although staff were sometimes slow, he received his medications in pudding and assistance with showers. Resident A stated he had required hospitalization four times because of his legs. I observed Resident A's bilateral lower extremities were elevated in the recliner which were wrapped and appeared swollen.

While on-site, I interviewed Employee #1 who stated Resident A was hospitalized for swollen legs as well as for his behaviors. Employee #1 stated Resident A was a standby assist with changing his briefs, dressing and toileting due to his swollen legs. Employee #1 stated staff encouraged Resident A to sit with his legs elevated to reduce the swelling. Employee #1 stated Resident A also had home care services for care and treatment of his legs in which staff followed their orders.

I reviewed Resident A's face sheet which read he admitted to the facility on 4/25/2022 and that his emergency contact was his guardian.

I reviewed Resident A's guardianship paperwork which read consistent with statements from Ms. Workman.

I reviewed Resident A's service plan dated 4/25/2022 and updated on 7/18/2022 which read consistent with statements from Employee #1. The plan in part read Resident A required one person assist for personal hygiene, bathing, dressing/undressing, nighttime care, transferring and mobility. The plan in part read resident was both continent and incontinent in which he would take himself to the bathroom and utilized the grab bars while in the bathroom. The plan read staff were to check the resident to ensure he was dry due to increased incontinence.

I reviewed the Point of Care Audit Reports for Resident A dated August and September 2022 which read staff documented each shift assistance with bowel elimination, oral care, and showers twice weekly.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Staff attestations and review of Resident A's service plan revealed he required assistance with activities of daily living including changing his briefs. Review of documentation revealed staff documented care provided which was consistent with his service plan. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive his medications as prescribed.

INVESTIGATION:

On 9/12/2022, the department received a complaint through the online complaint system Resident A's medications were not given as prescribed.

On 10/18/2022, I conducted an on-site inspection at the facility. I interviewed administrator Ms. Workman who stated Resident A had received his medications as prescribed. Ms. Workman stated after one of Resident A's hospitalizations, the facility received hospital discharge orders which read most of his medications were discontinued. Ms. Workman stated facility staff reviewed the hospital discharge orders with Resident A's physician who prescribed the medications that were to be administered.

While on-site, I reviewed the discharge orders dated 9/6/2022 which read consistent with statements from Ms. Workman.

While on-site, I interviewed Resident A who stated he received his medications with pudding.

While on-site, I interviewed Employee #1 who stated Resident A could recognize his medications and usually took them as prescribed.

I reviewed Resident A's service plan which read medications were administered by wellness staff.

I reviewed Resident A's August and September 2022 medication administration records (MARs) which read staff initialed his medications as prescribed, however one or more doses of medication on following dates were left blank 8/6/2022, 9/24/2022, 9/28/2022, and 9/30/2022.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Staff attestations and review of Resident A's service plan revealed staff were to administer his medications as prescribed in the electronic medical record. Review of Resident A's MARs revealed there were dates left blank in which it could not be determined if Resident A's medications were administered or not, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was improperly charged after going to rehabilitation.

INVESTIGATION:

On 9/12/2022, the department received a complaint through the online complaint system which read Resident A had left the facility for months and they were charging him.

On 10/18/2022, I conducted an on-site inspection at the facility. I interviewed administrator Ms. Workman who stated if a resident's personal property was in the apartment, then they are charged. Ms. Workman stated after one of Resident A's hospitalizations, he required skilled nursing care.

I reviewed Resident A's contract dated 4/25/2022 signed by Relative A1 which consistent with Ms. Workman's statements. The contract read in part:

If the Resident does not wish to pay the Monthly Residency Fee while the Resident is out at the hospital, the Resident must notify the ALC of his/her intention to terminate this Agreement and must vacate the Unit immediately of all belongings and furniture. If Resident has been transferred to a hospital, this Agreement will not be considered terminated and Resident's obligation to pay the Monthly Residency Fee shall not cease until the Resident's Unit is empty of all belongings and furniture.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home. The resident admission contract shall, at a minimum, specify all of the following: **(b) The services to be provided and the fees for the services.**
ANALYSIS:	Staff attestations and review of Resident A's signed contract revealed there was an obligation to pay the monthly residency fee while a resident was out of the facility unless the facility was notified, and their personal items were removed from premises. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

On 9/12/2022, the department received a complaint through the online complaint system which read the facility was understaffed.

On 10/18/2022, I conducted an on-site inspection at the facility. I interviewed administrator Ms. Workman who stated there were three shifts, 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Ms. Workman stated in August 2022, there were approximately 29 residents in which each shift was staffed with two staff persons. Ms. Workman stated in September 2022, there were approximately 32

residents in which each shift was staff with two staff persons. Ms. Workman stated the resident census increased so she increased staffing to include a staff member on duty from 7:00 AM to 11:00 AM and from 5:00 PM to 9:00 PM. Ms. Workman stated most of the residents required a standby or one person assist. Ms. Workman stated there was one resident who required a two person assist.

While on-site, I interviewed Employee #1 who statements were consistent with Ms. Workman. Employee #1 stated there was a resident who required a two person assist. Employee #1 stated there was another resident who required a two person assist intermittently.

I reviewed the resident roster which read consistent with statements from Ms. Workman.

I reviewed an employee list which read there were 17 care staff, one activities director, and one nurse.

I reviewed the staffing schedules for August and September 2022 which read consistent with staff interviews.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff attestations revealed there were one or two residents who required assistance of two staff. Review of documentation revealed the staff schedule read consistent with the needs of the residents. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/28/2022, I shared the findings of this report with authorized representative Pamela Workman. Ms. Workman verbalized understanding of the findings.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of this license remain unchanged.

10/27/2022

Jessica Rogers Date
Licensing Staff

Approved By:

11/28/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section